# UNM Medical Plan Summary Administered by UNM Health
# July 1, 2016 to June 30, 2017

| **UNM Medical Plan**<br>**Pre-existing condition exclusions: NONE**<br>**Lifetime Maximum: NONE**<br>**Note: Services outside LoboCare Network require prior authorization** | **Please refer to your Participant Benefit Booklet for detailed information about UNM Medical Plan coverage including limitations, exclusions, and benefit certification requirements** | | |
|---|---|---|---|
| | **LoboCare Network** | **Extended Tier 2 Network (Prior Authorization Required)** | **Out-of-Network****** |
| **Deductible** | $600 Per Person ($1,200 Family) | | $1,800 Per Person ($3,600 Family) |
| **Out-of-Pocket Maximums** | $3,000 Per Person ($6,000 Family)** | | $7,500 Per Person ($15,000 Family) (Deductible not included) |
| **Inpatient Hospitalization** | 10% | 30% | 40%*** |
| **Outpatient Procedures** | 10% | 30% | 40%*** |
| **Physician Services:**<br>Primary Care (PC) Office Visits<br>Specialist Office Visits<br>Preventive Exams/Services<br>Outpatient Diagnostic Tests/lab/X-Ray(not including CT/ PET Scans, MRI, or Nuclear Medicine) | <br>$25 Copay*<br>$35 Copay*<br>No Copay<br>No Charge above Initial Office Visit Copay | <br>$30 Copay*<br>$45 Copay*<br>No Copay<br>No Charge above Initial Office Visit Copay | <br>40%***<br>40%***<br>Not Covered<br>Preventive Not Covered<br>Diagnostic 40%*** |
| **CT/PET scans, MRI, Nuclear Medicine** | 10% | 30% | 40%*** |
| **Durable Medical Equipment**<br>(Includes prosthetics; orthotics not covered) | 10% | 30% | 40%*** |
| **Mental Health/Substance Addiction**<br>Inpatient<br>Outpatient | <br>10%<br>$35 Copay* | <br>30%<br>$45 Copay* | <br>40%***<br>40%*** |
| **Home Health Care**<br>**(100 Visits Per Plan Year)** | 10% | 30% | 40%*** |
| **Skilled Nursing Care**<br>**(60 days/plan year)** | 10% | 30% | 40%*** |
| **Speech / Physical / Occupational Therapy (30 visits Physical/ 20 visits Speech and Occupational Therapy each per plan year)** | $35 Copay* | $45 Copay* | 40%*** |
| **Hospice** | 10% | 30% | 40%*** |
| **Ambulance** | Applies to In-Network Benefit** | 30% | Applies to In-Network Benefit** |
| **World-Wide Emergency Services** | $150 Copay* | $150 Copay* | $150 Copay* |
| **Urgent Care** | $75 Copay* | $75 Copay* | 40%*** |
| **Chiropractic (20 visits each per plan year)** | $35 Copay* | $45 Copay* | 40%*** |
| **Acupuncture** (**20 visits each per plan year)** | $35 Copay* | $45 Copay* | 40%*** |

| **Prescription Drugs** | | **Pharmacy/30 Day Supply**** | **Mail Order/Pharmacy 90 Day Supply**** |
|---|---|---|---|
| **Administered by Express Scripts, Inc.** | **Generic*:** | $10 Copay | $20 Copay |
| | **Formulary Brand*:** | 25% coinsurance *(Min $35 – Max $70)* | 25% coinsurance *(Min $87.50–Max $175)* |
| | **Non-Formulary*:** | 25% coinsurance *(Min $55 – Max $110)* | 25% coinsurance *(Min $137.50–Max $275.00)* |
| | **Specialty*:** | 20% to maximum $250/prescription; after reaching $1,250 out of pocket within plan year, then $55 Co-Pay | Not Available |

***Not Subject to Deductible**

****Combined LoboCare and In-Network Out-of-Pocket Maximums include deductibles, flat dollar copays, and coinsurance paid**

*****Applies to Out-of-Network Deductible and Out-of-Pocket Maximum**

******Amounts above Reasonable and Customary are not covered**